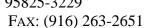


## MEDICAL BOARD OF CALIFORNIA BOARD OF PODIATRIC MEDICINE 1420 HOWE AVENUE, SUITE 8 SACRAMENTO, CA 95825-3229





PHONE: (916) 263-2647 FAX: (9
INTERNET: WWW.BPM.CA.GOV

## **WAIVER APPLICATION**

Please type or print clearly	<b>'.</b>			
Name:				
Last		First	Middle	
Address:				
City		State	Zip	
Phone Number: ()		Date of Birth:		
License Number:		<u> </u>		
Waiver Type (check all that apply):		TEMPORARY	PERMANENT	
	CME			
CONTINU	ING COMPETENCE			
Please check the category	which most appropriate	ly indicates the reason why you	are requesting a waiver.	
<u>Retirement</u> :	When requesting a waiver due to retirement, please indicate the number of patient visits you anticipate for the current license period (). Note: Any licensee so exempted by reason of retirement may not routinely engage in the practice of podiatric medicine and his/her podiatric medical practice shall be restricted as follows:			
1. Any examining	, treating and prescribing	ng is limited to 20 patients annua	ılly.	
to prescribe f	•	ontrolled substances unless othe the licensee's Drug Enforce as.	•	
3. Irrespective of	Irrespective of age, any income derived from the practice of podiatric medicine shall not exceed the			

(over)

net annual income allowed for recipients of social security benefits.

	Health:		plete and sign the appropriate information menting the illness or disability that prevents s. Use additional paper if needed.
	Describe Illness/	Disability:	
		timated length of disability:	
	Name of attending	ng physician (print)	License Number
			() Phone Number
	Address		
	Signature of Atte	ending Physician/Date	
	Military Service	When requesting a waiver due must be attached.	to military service, verification of service
	<u>Undue Hardshi</u> j	<b>p</b> : Explain and attach verifying de	ocumentation as appropriate.
		-CERTIFICATION-	
			of California that the foregoing information at to the best of my knowledge."
SI	GNATURE		DATE